19 November 2020

Introduction to the new Nursing OSCE APIE

Linda Everet
Assistant Director, Professional Regulation

Housekeeping

- Everyone, except the presenters, are automatically muted
- The “raise your hand” feature will not be used today
- Use the “?” feature or speech bubble to submit any questions or comments at any time
- Audio-only participants can email questions and comments to ToC@nmc-uk.org
- We may not be able to address individual points but everything is being noted for consideration
- You can download the slides using the resource function
- The session will be recorded

Today's agenda

9:00 am	**Welcome, scene setting and latest NMC updates** Linda Everet, Assistant Director, NMC
9:05 am	**Overview of the OSCE design** Sarah Maughan, Director, AlphaPlus
9:15 am	**Examples of APIE content** Sarah Maughan, Director, AlphaPlus
9:35 am	**Support Materials** Sarah Maughan, Director, AlphaPlus
9:40 am	**Q&A session** Jack Bland, Senior International Registration Manager, NMC Linda Everet, Assistant Director, NMC Penny Howard, Assessment Lead for Nursing, School of Health Sciences, The University of Nottingham Sarah Maughan, Director, AlphaPlus
9:55 am	**Next steps and closing** Linda Everet, Assistant Director, NMC

Previous webinars

- Over 300 people joined our first two webinars: Overview of the new Test of Competence and the new Computer Based Test (CBT)
- Thank you to everyone who attended, asked questions and submitted feedback
- If you weren't able to join these webinars, you can watch the recordings and download the presentation slides on our website **www.nmc.org.uk/registration/toc-review**

NMC Test of Competence: Nursing OSCE APIE

Alpha*Plus* Consultancy Ltd.

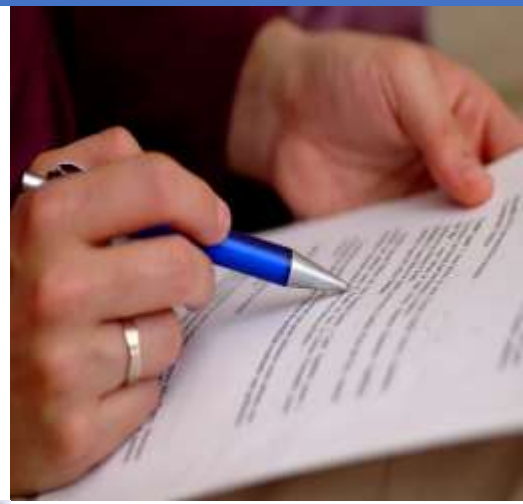
November 2020

Partnership

We work in partnership with our clients. This is more than a cliché for us: we care about the services we provide and the impact they have on learners. Experience has shown us that the best impact our work can have is when it is undertaken alongside our clients so we make partnership a key feature of our project approach and management method.

Quality

We manage projects effectively and to the highest quality, freeing up experts to concentrate on their specialism, but ensuring that activities are manage to meet expectations. This means only making promises that we know we can keep, and remembering the promises we have made to make sure we deliver.



Expertise

We ensure our teams consist of genuine sector experts with understanding in breadth and depth of both the theory and the practical complex everyday challenges faced by education providers.

Development

We are committed to the improvement of our staff, both to promote the long-term development of our business and as an end in itself: we believe in the value of education for all.

Educationalists

We are educationalists with a strong commitment to improving teaching, learning and assessment, based on intellectual integrity, sound evidence and innovative approaches.

Overview of OSCE design

The APIE

A Assessment
P Planning
I Implementation
E Evaluation

- An established means of assessing practical clinical practice
- Provides a means of assessing holistic practice – following a patient through their treatment by using a common scenario
- Used in current Test of Competence – some updates in the new Test to make it a better assessment of the new standards
- Some re-purposing of existing APIEs and some new scenarios

Format of the new test of competence: Nursing

	Current	Future		
Test		**Format**	**Marks**	**Timing**
CBT	Single test of 120 questions lasting 3 hours	Part A: Numeracy	15	30 minutes
		Part B: Clinical	100	2 hours and 30 minutes
OSCE	6 stations 4 station 'APIE' • Assessment • Planning • Implement ation • Evaluation 2 skill stations	10 stations 4 station 'APIE' • Assessment • Planning • Implementation • Evaluation 6 skill stations • 2 pairs of 2 skills • 1 professional values • 1 critical appraisal	Variable by station according to task-specific criteria	Up to 2 hours and 45 minutes APIE stations: • Assessment station: 20 • Planning station: 14 • Implementation station: 16 • Evaluation station: 14 Skills stations, critical appraisal and professional values stations: • 16 minutes for each pairing

Format of the new test of competence: Nursing

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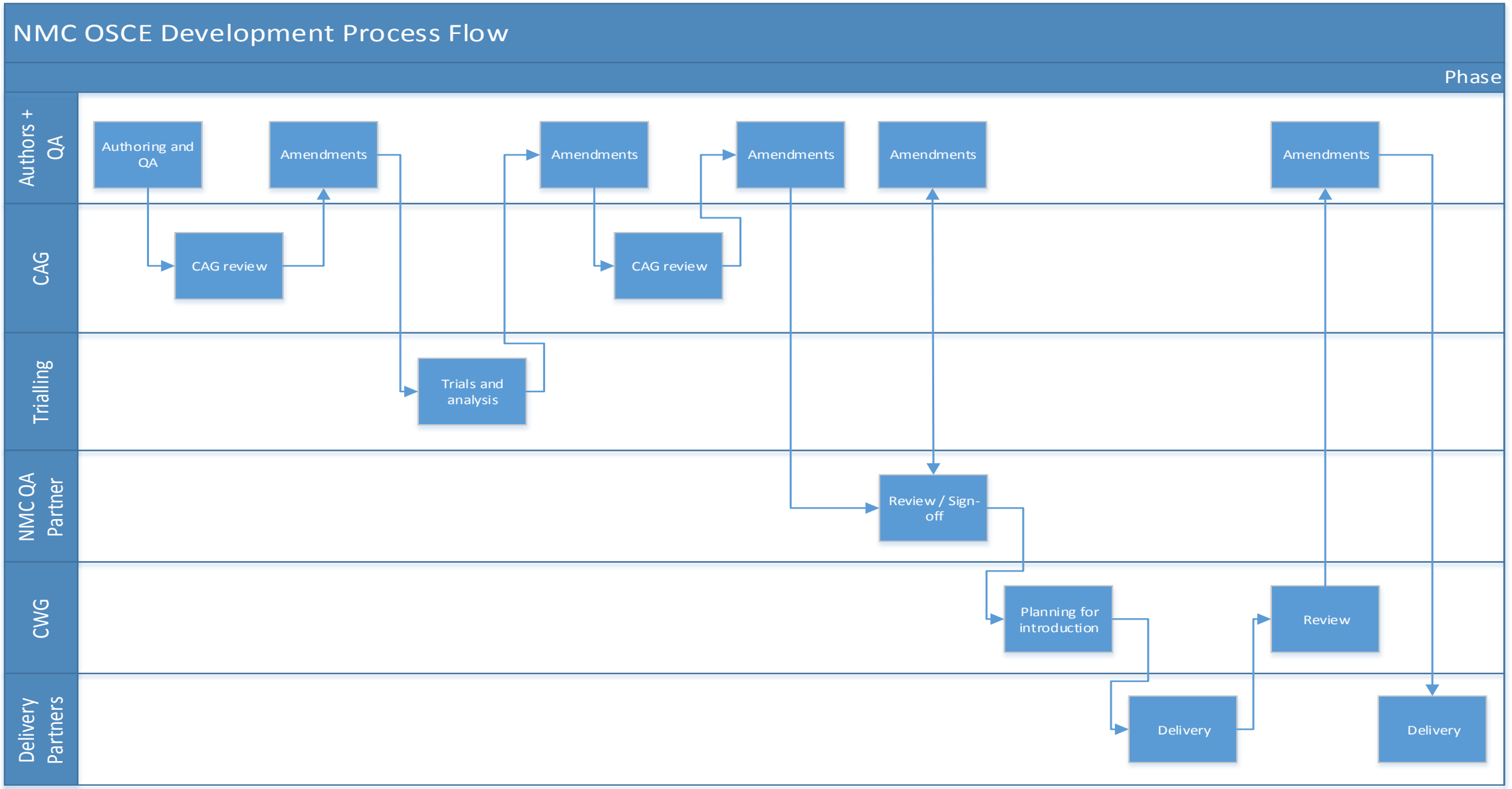
Test		**Format**	**Marks**	**Timing**
CBT	Single test of 120 questions lasting 3 hours	Part A: Numeracy	15	30 minutes
		Part B: Clinical	100	2 hours and 30 minutes
OSCE	6 stations	10 stations		Up to 2 hours and 45 minutes
	4 station 'APIE' • Assessment • Planning • Implementation • Evaluation	4 station 'APIE' • Assessment • Planning • Implementation • Evaluation	Variable by station according to task-specific criteria	APIE stations: • Assessment station: 20 • Planning station: 14 • Implementation station: 16 • Evaluation station: 10
	2 skill stations	6 skill stations • 2 pairs of 2 skills • 1 professional values • 1 critical appraisal		Skills stations, critical appraisal and professional values stations: • 16 minutes for each pairing

The development process



Test Design

- Multiple OSCE forms:
  - Fixed station grouping to ensure broadest possible coverage of standards and comparability between different OSCEs
  - Some overlapping skills stations between different OSCEs
  - Candidates will resit the same station(s) if they fail
  - New OSCE forms being added over time and new groupings of stations
- Assessors mark against a list of criteria:
  - Demonstrated/ not demonstrated
  - Demonstrated/ partially demonstrated/ not demonstrated
- Assessors also make a holistic judgement (to be used for standards setting and monitoring)
- A set of red flags are also used for each station

OSCE overview: adult nursing

RN1	A	P	I	E	Skill 1	Skill 2	Skill 3	Skill 4	Skill 5	Skill 6
					Clinical	Clinical	Clinical	Clinical	Professional values/ bahaviour	Appraising evidence based practice
Pneumonia										
Subdural										
Anxiety										
Hernia										
Asthma										
Chronic cardiac failure										
Ectopic										
Community										
Fall and fracture										
Homelessness										

Key:

Re-purposed: least changes

Re-purposed: significant changes

New

OSCE overview: other fields

		A	P	I	E	Skill 1	Skill 2	Skill 3	Skill 4	Skill 5	Skill 6
						Clinical	Clinical	Clinical	Clinical	Professional values/ behaviours	Appraising evidence-based practice
RN3: mental health	**Depression and suicide ideation**										
RN5: learning disabilities	**Behaviours that challenge**										
RN8: children's	**Asthma**										

Re-purposed, least change
Re-purposed, signifcant change
New

Examples of APIE content

Assessment: Candidate briefing

Please conduct a holistic assessment assessing the patient's physical, psychosocial, spiritual and sexual care needs.

As part of your assessment please complete an A – E assessment (Airway, Breathing, Circulation, Disability, Exposure), and take and record the patient vital signs (blood pressure, temperature, pulse rate, oxygen saturations, respiratory rate) and calculate a National Early Warning Score 2 (NEWS2) score.

Depending on the patient's circumstances and condition you may wish to focus on some areas of assessment in more depth than others.

- Please note, a sheet of paper is provided so candidates can write notes
- The notes are not assessed (nor is the verbal input) – the completed NEWS2 is assessed

Patient Overview

Name: Ash Potter
Date of Birth: 01/01/1950 (70 years old in 2020)
Address: 1 Sweet Street, Westshire
Post Code: WW6 5PQ
GP: Dr Biswaz, The Plains Surgery, Westshire

Presenting Complaint:

- Recalled following bowel screening and undergone a rigid sigmoidoscopy.
- Diagnosed with a small primary colorectal cancer.
- Undergone a laparoscopic hemicolectomy which was uncomplicated and no stoma necessary.
- Now attending the surgical assessment unit ten days after surgery with a 5cm wound at the surgical (extraction) site. The wound is inflamed with some exudate.
- Ash expresses feeling hot and more tired than usually.
- Reduced dietary and fluid intake since surgery and has not opened bowels for four days
- Feeling emotionally 'low' and expressing abdominal pain.
- Walked unaided before surgery, finding it more difficult due to abdominal pain.

Past Medical History:

- Broken arm aged 8
- Hypertension since 2005
- Glaucoma since 2017

Social History:

- Normally lives and cares for partner who suffers with slight cognitive impairment. Partner currently staying with daughter Jenny since Ash was admitted to hospital. Ash refused to stay with Jenny as didn't want to leave own home.
- Lives in two storey house
- Non smoker
- Drinks at least two pints of lager every day, sometimes more.
- Daughter or Son-in- law visits every other day and bringing meals.

Drug History:

- Ramipril 5 milligrams, once a day.
- Timoptol 0.5% eye drops, one drop, both eyes, twice daily.
- Paracetamol 1 gram as required.

Allergies: No known allergies

Id	Assessment Criteria
1	Assesses the safety of the scene and privacy and dignity of the patient.
2	Cleans hands with alcohol hand rub, or wash with soap and water and dry with paper towels following WHO guidelines.
3	Introduces self to person.
4	Checks ID with person (person's name is essential and either their date of birth or hospital number) verbally, against wristband (where appropriate) and documentation.
5	Checks for allergies verbally and on wrist band (where appropriate).
6	Gains consent and explains reason for the assessment.
7	Uses a calm voice, speech is clear, body language is open, personal space appropriate.
8	Conducts an A-E assessment **(please refer to examiner guidance for specific scenarios); v**erbalisation allowed:
8a	**Airway:** clear, no visual obstructions
8b	**Breathing:** Respiratory rate; rhythm; depth; oxygen saturation level; respiratory noises; unequal air entry; visual signs of respiratory distress
8c	**Circulation:** Heart rate; rhythm; strength; blood pressure; capillary refill; pallor and perfusion
8d	**Disability**: conscious level using ACVPU; presence of pain; urine output; blood glucose
8e	**Exposure**: Takes and records temperature; asks for the presence of bleeds, rashes, injuries; obtains a medical history
9	Accurately measures and documents the patient's vital signs and specific assessment tools.
10	Calculates NEWS2 score accurately. For subdural scenario only: accurately calculate Glasgow Coma Scale.
11	Accurately completes document: sign, date and time on assessment charts.
12	Conducts a holistic assessment relevant to the patient's scenario.
13	Disposes of equipment appropriately - verbalisation accepted.
14	Cleans hands with alcohol hand rub, or wash with soap and water and dry with paper towels following WHO guidelines - verbalisation accepted.
15	Acts professionally throughout procedure in accordance with the NMC (2018) The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates.

Planning

Scenario
Ash Potter was referred to the surgical assessment unit after presenting ten days post operatively with an inflamed abdominal wound and pain following an uncomplicated laparoscopic hemicolectomy to remove a small primary colorectal cancer.

- Based on your nursing assessment please produce a nursing care plan for 2 relevant aspects of nursing care suitable for the next 24 hours.
- This is a silent written station. Please ensure you write legibly and clearly.

Planning Form

Patient Details: Name: Ash Potter Hospital number: 0004321 Address: 1 Sweet Street, Westshire, WW6 5PQ Date of Birth: 01/01/1950 (70 years old in 2020)
Nursing problem / need
Aim(s) of care:
Re-evaluation date:
Nursing interventions

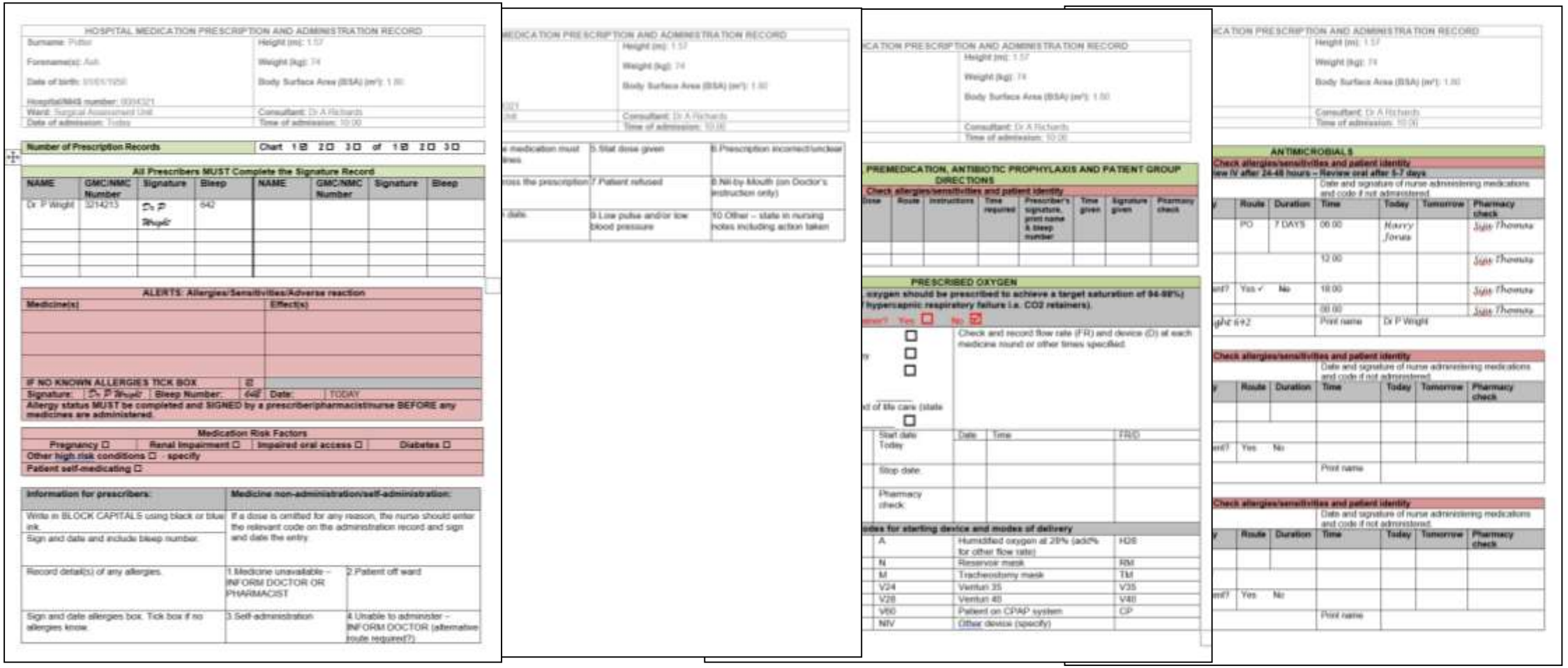
Id	Assessment Criteria
1	Clearly and legibly handwrites answers.
2	Identifies two relevant nursing problems/needs.
3	Identifies aims for both problems.
4	Sets appropriate evaluation date for both problems.
5	Ensures nursing interventions are current/evidence based/best practice.
6	Uses professional terminology in care planning.
7	Does not use abbreviations or acronyms.
8	Ensures strike-through errors retain legibility.
9	Accurately print, sign and date.
10	Acts professionally throughout procedure in accordance with the NMC (2018) The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates.

Implementing Care

Scenario
Ash Potter was admitted to the surgical assessment unit after presenting with an infected abdominal wound, mild pain and constipation following an uncomplicated laparoscopic hemicolectomy to remove a small primary colorectal cancer.

- Talk to the person.
- Please verbalise what you are doing and why to the examiner.
- Read out the chart and explain what you are checking/giving/not giving and why.
- Complete all the required drug administration checks.
- Complete the documentation and use the correct codes.
- The correct codes for non-administration are on the chart.
- Check and complete the last page of the chart.

New Drugs Chart



HOSPITAL MEDICATION PRESCRIPTION AND ADMINISTRATION RECORD

Number of Prescription Records | Chart 1 2 3 of 1 2 3

All Prescribers MUST Complete the Signature Record

NAME	GMC/NMC Number	Signature	Bleep	NAME	GMC/NMC Number	Signature	Bleep
Dr P Wright	3214213	P Wright	642				

ALERTS: Allergies/Sensitivities/Adverse reaction

Medicine(s)	Effect(s)
IF NO KNOWN ALLERGIES TICK BOX	☑

Signature: P Wright | Bleep Number: 642 | Date: TODAY

Allergy status MUST be completed and SIGNED by a prescriber/pharmacist/nurse BEFORE any medicines are administered.

Medication Risk Factors

Pregnancy ☐	Renal impairment ☐	Impaired oral access ☐	Diabetes ☐

Other high risk conditions ☐ - specify

Patient self-medicating ☐

Information for prescribers:	Medicine non-administration/self-administration:	
Write in BLOCK CAPITALS using black or blue ink. Sign and date and include bleep number.	If a dose is omitted for any reason, the nurse should enter the relevant code on the administration record and sign and date the entry.	
Record detail(s) of any allergies.	1 Medicine unavailable – INFORM DOCTOR OR PHARMACIST	2 Patient off ward
Sign and date allergies box. Tick box if no allergies know.	3 Self-administration	4 Unable to administer – INFORM DOCTOR (alternative route required?)

5 Stat dose given	8 Prescription incorrect/unclear	
7 Patient refused	9 Nil-by-Mouth (on Doctor's instruction only)	
9 Low pulse and/or low blood pressure	10 Other – state in nursing notes including action taken	

PREMEDICATION, ANTIBIOTIC PROPHYLAXIS AND PATIENT GROUP DIRECTIONS

Check allergies/sensitivities and patient identity

Dose	Route	Instructions	Time required	Prescriber's signature, print name & bleep number	Time given	Signature given	Pharmacy check

PRESCRIBED OXYGEN

oxygen should be prescribed to achieve a target saturation of 94-98%) hypercapnic respiratory failure i.e. CO2 retainers).

Check and record flow rate (FR) and device (D) at each medicine round or other times specified.

	Start date Today	Date	Time	FR/D
	Stop date			
	Pharmacy check			

odes for starting device and modes of delivery

A	Humidified oxygen at 28% (adj% for other flow rate)	HDI
N	Reservoir mask	RM
M	Tracheostomy mask	TM
V24	Venturi 35	V35
V28	Venturi 40	V40
V60	Patient on CPAP system	CP
NIV	Other device (specify)	

ANTIMICROBIALS

Check allergies/sensitivities and patient identity

ew IV after 24-48 hours – Review oral after 5-7 days

Date and signature of nurse administering medications and code if not administered

Route	Duration	Time	Today	Tomorrow	Pharmacy check
PO	7 DAYS	06:00	Harry Jones		Sign Thomas
		12:00			Sign Thomas
		18:00			Sign Thomas
		00:00			Sign Thomas

Yes ✓ No

Print name: Dr P Wright

Check allergies/sensitivities and patient identity

Date and signature of nurse administering medications and code if not administered

Route	Duration	Time	Today	Tomorrow	Pharmacy check

Yes No

Print name

Check allergies/sensitivities and patient identity

Date and signature of nurse administering medications and code if not administered

Route	Duration	Time	Today	Tomorrow	Pharmacy check

Yes No

Print name

Id	Assessment Criteria
1	Cleans hands with alcohol hand rub, or wash with soap and water and dry with paper towels following WHO guidelines.
2	Introduces self to person.
3	Seeks consent from person or carer prior to administering medication.
4	Checks allergies on chart and confirms with the person in their care, also note red ID wristband (where appropriate).
5	Before administering any prescribed drug, looks at the person's prescription chart and correctly checks **ALL** of the following: Correct: • Person (Check ID with person: verbally, against wristband (where appropriate) and documentation), • Drug • Dose • Date and time of administration • Route and method of administration • Diluent (as appropriate) • Any Allergies.
6	Correctly checks **ALL** of the following*:* • Validity of prescription • Signature of prescriber • Prescription is legible If any of these pieces of information are missing, are unclear or illegible then the nurse should not proceed with administration and should consult the prescriber.
7	Considers contraindication where relevant and medical information prior to administration (prompt permitted) (this may not be relevant in all scenarios).
8	Provides a correct explanation of what each drug being administered is for to the person in their care (prompt permitted).
9	Administers drugs due for administration correctly and safely.
10	Omits drugs not to be administered and provides verbal rationale (ask candidate reason for non-administration if not verbalised).
11	Accurately documents drug administration and non-administration.
12	Acts professionally throughout procedure in accordance with the NMC (2018) The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates.

Evaluating Care

Scenario
Ash Potter was admitted to the surgical assessment unit after presenting with an infected abdominal wound, mild pain and constipation following a laparoscopic hemicolectomy. Ash has received analgesia, antibiotics and laxatives however continues to feel hot, tired and unwell. Ash's most recent observations were: •Temperature: 38.4^{0}C •Pulse: 92bpm •Respirations: 20bpm •Oxygen Saturations: 96% on air •Blood Pressure: 108/59 NEWS2 score = 3

- Using the Situation, Background, Assessment and Recommendation (SBAR) tool please make notes regarding your patient **and use this to verbally hand information over** to the doctor overseeing Ash's care (examiner).
- You have **8 minutes** to make notes on the SBAR form (this is not assessed) and up to **5 minutes** to complete the verbal handover to the examiner.

Id	Assessment Criteria
Situation	
1a	Introduces self and the clinical setting.
1b	States the patient's name, hospital number and/or DoB, and location.
1c	States the reason for the handover (where relevant).
Background	
2a	States date of admission / visit / reason for initial admission / referral to specialist team and diagnosis.
2b	Notes previous medical history and relevant medication/social history.
2c	Gives details of current events and detailing findings from assessment.
Assessment	
3a	States most recent observations, any results from assessments undertaken and what changes have occurred.
3b	Identifies main nursing needs.
3c	States nursing and medical interventions completed.
3d	States areas of concerns.
Recommendation	
4	States what is required of the person taking the handover and proposes a realistic plan of action.
Overall	
5	Verbal communication is clear and appropriate.
6	Systematic and structured approach taken to handover.
7	Acts professionally throughout procedure in accordance with the NMC (2018) The Code: Professional standards of practice and behaviour for nurses, midwives and nursing associates.

Support Materials

Candidate Support

- The examples used in this presentation are taken from the candidate support materials
- These support materials will be available in advance from the learning platforms held by each of the Test Centres in the new year
- There is more information about the support materials in the Overview presentation which was recorded and can be found www.nmc.org.uk/registration/toc-review

Q&A session

Next steps

Next steps

Coming up

- The new Test of Competence (nursing) - OSCE skills stations, **Thursday 26 November**, 9:00 to 10:00

- The new Test of Competence (midwifery) - OSCE APIE and skills stations, **Monday 30 November,** 12:30 to 13:30

- The new Test of Competence (nursing associates) - OSCE APIE and skills stations, **Thursday 3 December**, 14:30 to 15:30

- Register on our website - https://www.nmc.org.uk/registration/toc-review/

- Sign up for monthly updates - https://r1.dotmailer-surveys.com/b2129ae8-114gax68

Thank you